08279

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: A. A. Co.

City or town: Carvel Beach
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: --

How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: A. A. Co.

City or town: Carvel Beach
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Stoney Creek Road
(If rural, give LOCATION)

2.(a) If veteran, name war: --

3. (a) FULL NAME: Albert Wayne Anthony

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Married

6.(b) Name of husband or wife: Anna (Burrier)

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 9/9/1862

8. AGE: Years	Months	Days	If less than one day
77	10	26	--- hrs. ----- min.

9. Birthplace: Kent Co. Md.
(Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business

FATHER
12. Name: Samuel Anthony
13. Birthplace: Kent Co. Md.

MOTHER
14. Maiden name: Sarah E. Dillehunt
15. Birthplace: Kent Co. Md.

16. Informant: Mrs. Anna Anthony
Carvel Beach
Address: Stoney Creek Rd. A.A.Co.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8/7/1940 (month) (day) (year)

Cemetery or crematory: Woodlawn Cem. Balto. Co. Md.

Location: Baltimore Co. Md.

18. Funeral director: George J. Ruth Jr. George J. Ruth, Inc.

Address: 1735-Harford Ave. Balto. Md.

19. 8-5 19 40 (Date rec'd by registrar) L. A. Brett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/4/40 19 ..., at 9 30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/27/40 19 ..., to 8/4/40 19 ..., and that I last saw him alive on 8/4/40 19 ...

Immediate cause of death: Cerebral hemorrhage — DURATION: 1 day

Due to: Arteriosclerosis

Due to: Chronic Endocarditis — unknown

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: John J. Alexander M. D. or other

Address: Glen Burnie Date signed: 8/5/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 8 1940
BUREAU V. S.

08280

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Eastport Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 515 Sixth

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Kate J. Bennett

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widow

6.(b) Name of husband or wife: John Bennett

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jany 25th 1858

8. AGE: Years 82 Months 7 Days 2 If less than one day ..... hrs. ..... min.

9. Birthplace: London England (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER

12. Name: James Waymark

13. Birthplace: France

MOTHER

14. Maiden name: Mary Loveday

15. Birthplace: England

18. Informant: John W. Bennett

Address: 515 Sixth St. Eastport Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 30th 1940 (month) (day) (year)

Cemetery or crematory: Cedar Bldg.

Location: Annapolis Md

18. Funeral director: John M. Taylor

Address: Annapolis Md.

19. 8-27th 1940 (Date rec'd by registrar) J J Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8-27 1940, at 4 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 1st 1940, to Aug 27 1940 and that I last saw her alive on Aug 27th 1940

Immediate cause of death: Myocarditis (chr) & Myocardial Insufficiency — DURATION: unknown

Due to: Hypertension — unknown

Due to: Arterio Sclerosis — unknown

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: George C. Bosil M. D. or other

Address: Annapolis Md Date signed: 8-27-40

VS A15 (T) (I) (M) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08281

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: A. A. Co.
City or town: - Severn P. O. -
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or Institution:
Stay in hospital or Inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A. Co.
City or town: - Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Quarterfield Rd.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Rose Marie Benton

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Married

6 (b) Name of husband or wife: George F
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 3 - 1918

8. AGE:

Years	Months	Days	If less than one day
21	10	3	hrs. min.

9. Birthplace: A. A. Co. Md.
(Town, county, and state)
10. Usual occupation: House wife
11. Industry or business:
FATHER 12. Name: Christian Schoolman
13. Birthplace: Germany
MOTHER 14. Maiden name: Emilie Hund
15. Birthplace: Germany
16. Informant: George F Benton
Address: Quarterfield Rd. A.A. Co.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 8 1940 (month) (day) (year)
Cemetery or crematory: Glen Haven Cem
Location: Glen Burnie
18. Funeral director: Wm Cook
Address: 217 St Paul St.
19. Aug 7 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/6/40 19 , at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/5/40 19 to 8/6/40 19 , and that I last saw her alive on 8/5/40 19 .

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 day.
Due to Hypostatic Pneumonia.	
Due to	
Other conditions Rheumatic Endocarditis Cardiac hypertrophy	Unknown.

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John J. Alexander M. D. or other
Address: Glen Burnie Date signed 8/6/40

RECEIVED
SEP 5 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

08282

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Cumberstone

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: A. A. Co.

City or town: Cumberstone Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: None

3. (a) FULL NAME: Moses Brent

3. (b) Social Security Number: None

4. Sex: Male

5. Color or race: Col

6. (a) ~~Single, married,~~ widowed, ~~or divorced~~: Widowed

6 (b) Name of husband or wife: Rachael Rawlings Brent

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): March 13 1861

8. AGE: Years 79 | Months 4 | Days 18 | If less than one day ____ hrs. ____ min.

9. Birthplace: Prince George (Town, county, and state)

10. Usual occupation: Farm Hand

11. Industry or business: Farm

FATHER

12. Name: Unknown

13. Birthplace

MOTHER

14. Maiden name: Susan Brent

15. Birthplace: Unknown

16. Informant: George Hebron

Address: Cumberstone, Md

17. Burial (Burial, ~~cremation~~, or removal. Which?) Date thereof 8 (month) 3 (day) 40 (year)

Cemetery or ~~crematory~~: Dan'l Star Cem.

Location: West River Md

18. Funeral director: F. A. Hardisty & Son

Address: Galesville Md.

19. Aug 2 1940 (Date recd by regiatrar) W. R. Clayton Regiatrar

Dis Lund

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 1 1940, at 6 00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 7 1940, to Aug 1 1940, and that I last saw him alive on July 28 1940.

Immediate cause of death: Appoplexy

Due to: Hypertension

Due to: Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION: 24 days

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: F. B. West M. D. or other

Address: Lothian Date signed 8/1/40

RECEIVED
SEP 7 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

08283

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crownsville State Hospital

Stay in hospital or inst. (yrs., or mos., or days): 15 days

Stay in this community (yrs., or mos., or days): 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: ------- Ward No. ----
(If outside city or town limits, write RURAL NEAR and give town)

Street No. ----------
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: ----------

3. (a) FULL NAME: Carrie Brooks

3. (b) Social Security Number: -------

4. Sex: Female

5. Color or race: Black

6. (a) Single, married, widowed, or divorced: Unknown

6 (b) Name of husband or wife: Unknown

----- 6(c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.): 1911

8. AGE: Years: 29 Months: Unknown Days: If less than one day: ---- hrs. ---- min.

9. Birthplace: Unknown
(Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business: Unknown

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Lancaster Co Va Date thereof: August 11-40
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: ~~Lancaster Co. Va.~~ Mt. Vernon Cem.

Location: Va. Richmond Co.

18. Funeral director: Mrs. George H. Holland

Address: 1631 Druid Hill Ave Balto. Md.

19. Aug 9 1940 (Date rec'd by registrar) E. F. Joyce D.L. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 9th 1940 at 6:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 26th 1940, to August 9 1940, and that I last saw her alive on August 9th 1940.

Immediate cause of death: Broncho Pneumonia

Due to: ------

Due to: -------

Other conditions: -------
(Include pregnancy within 3 months of death)

Major findings:

Of operations: -------

Of autopsy: ------

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur? ------ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: --- Injured at work? -----

23. SIGNATURE: Herbert P. Hinkwood M. D. or other

Address: Crownsville, Md. Date signed: 8/9/40

RECEIVED
AUG 23 1940
BUREAU V. S.

08284

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(97)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
CROWNSVILLE STATE HOSPITAL

How long in hospital or institution? 4 months, 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 308 Carrollton Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: ------

3. (a) FULL NAME
BENJAMIN BROWN #2

3. (b) Social Security Number
------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	widowed

6.(b) Name of ~~husband~~ or wife: Unknown

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1886

8. AGE:

Years	Months	Days	If less than one day
54	Unknown		..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: General

FATHER
12. Name: Benjamin Brown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Janie (Unknown)
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory: Mt. Auburn 8/8/40

Location: Baltimore City

18. Funeral director: Thomas E. Kelson

Address: 1303 Pressman St.

19. Aug 6 1940 (Date rec'd by registrar) E. F. Joyce D.L. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 5th 1940, at 4 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 11th 1940, to August 5 1940 and that I last saw him alive on August 5th 1940

Immediate cause of death	DURATION
Arteriosclerosis	
Due to	
Due to	
Other conditions: -----	

(Include pregnancy within 3 months of death)

Major findings of operations: -----

Date of op.

Autopsy results: -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: ----- Date of

Where did injury occur? -------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ------

Means of injury: Injured at work? -----

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Md. Date signed: 8/5/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 14 1940
BUREAU V. S.

08285

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Eastport, (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 607 Severn Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Eastport (If outside city or town limits, write RURAL and give nearest town)

Street No.: 607 Severn Ave. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: JAMES R. BROWN

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Fannie H. Brown

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 28, 1891

8. AGE:

Years	Months	Days	If less than one day
49	9	6	..... hrs. ..... min.

9. Birthplace: Anne Arundel County., Maryland (Town, county, and state)

10. Usual occupation: Fireman at U. S. Naval Academy

11. Industry or business

FATHER
12. Name: Charles H. Brown
13. Birthplace: A. A. Co. Md.

MOTHER
14. Maiden name: Susan Limore
15. Birthplace: A. A. Co. Md.

16. Informant: Fannie H. Brown

Address: Eastport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5 August 1940 (month) (day) (year)

Cemetery or crematory: Cedar Bluff Cemetery

Location: Annapolis, Md. Annapolis, Md.

18. Funeral director: John M. Taylor

Address: 147-9 Gloucester St. Annapolis, Md.

19. Aug 5th 1940 (Date rec'd by registrar) J J Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 3. 1940, at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post-mortem examination ~~[illegible]~~ Aug. 3 1940

Immediate cause of death: Coronary Thrombosis — DURATION: Sudden

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: John M. Claffy Deputy Medical Examiner. M. D. or other

Address: Annapolis Md. Date signed: 8/3/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
BUREAU U. S.

RECEIVED
AUG 26 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

08286

1. PLACE OF DEATH 30g

County Anne Arundel Registration Dist. No. 20

Village or City Nutwell. Md No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Frank Burgess If U. S. Veteran, specify WAR

(a) Residence: No. Nutwell, Md. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Col

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Ella Burgess

6. DATE OF BIRTH (month, day, and year): 1883 Apr 5th

7. AGE: Years 57 | 4 Months April | Days 20 5 | If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: Farmer Hand

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country): JEWELL, A.A. Co.

FATHER

13. NAME: Thomas Burgess

14. BIRTHPLACE (city or town) (State or country): Unknown

MOTHER

15. MAIDEN NAME: Henrietta Gray

16. BIRTHPLACE (city or town) (State or country): Nutwell Md

17. INFORMANT (Address): David Thompson Nutwell

18. BURIAL, ~~CREMATION, OR REMOVAL~~ Place: Friendship Date: Aug 28, 1940

19. UNDERTAKER (Address): T. A. Hardesty & Son Galesville Md

20. FILED: 8-28, 1940 W. R. Claytor Deputy Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Aug (Month) 25 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from July 1, 1940, to Aug 25, 1940

I last saw him alive on Aug 25, 1940; death is said to have occurred on the date stated above, at 10 P. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
acute myocardial insufficiency	

Other Contributory Causes of importance:

chronic myocarditis hypertension, syphilis

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury, 19

Where did Injury occur? (Specify city or town, county and State)

Specify whether Injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Emily H. Wilson M. D.

(Address) Lothian Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

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Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

08287

Reg. Dist. No. 20

1. PLACE OF DEATH:
County: A. A.
City or town: Galesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A. A. Co
City or town: Galesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Louise Hamphill

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col	Widow

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 9 — 1861

8. AGE: Years: 79 | Months: 3 | Days: 18 | If less than one day: hrs. min.

9. Birthplace: Howard Co., Md. (Town, county, and state)

10. Usual occupation: House work

11. Industry or business

FATHER — 12. Name: Walter Stewart
13. Birthplace: Howard Co. Md.

MOTHER — 14. Maiden name: Amelia Joyce
15. Birthplace: Howard Co. Md.

18. Informant: Martha Davis
Address: Galesville

17. Burial (Burial, cremation, or removal. Which?) Date thereof: August 29 1940 (month) (day) (year)
Cemetery: Catholic Cemetery
Location: West River, Md.

18. Funeral director: D. A. Steadley & Son
Address: Galesville, Md.

19. 8-28-1940 H. R. Clayton (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 27th 1940, at 5:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 10th 1940, to August 27th 1940
and that I last saw h[illegible] alive on August 27th 1940

Immediate cause of death	DURATION
Myocarditis, Chronic.	3 months
Due to: Duration: Six months. cwlsR. Accelerated Hypertension	8 months
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. F. Richardson M. D. or other
Address: 10 - Clay St. Annapolis Md. Date signed: 8/27/40

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

08288

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Emergency Hospital

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): One year

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Kansas County:

City or town: Wichita Ward No.: (If outside city or town limits, write RURAL NEAR and give town)

Street No.: (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: ----

3. (a) FULL NAME: Harley Mack Carrier

3. (b) Social Security Number: None

4. Sex: male

5. Color or race: white

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: ----

6(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 2-26-06

8. AGE: Years: 33 Months: 6 Days: 4 If less than one day: ---- hrs. ---- min.

9. Birthplace: Kansas (Town, county, and state)

10. Usual occupation: Mariner

11. Industry or business: U.S.Navy

FATHER
12. Name: Samuel S. Carrier
13. Birthplace: unknown

MOTHER
14. Maiden name: ----
15. Birthplace: ----

16. Informant: U.S.NAVY RECORDS.

Address: U.S.S.REINA MERCEDES, ANNAPOLIS, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 3 - 1940 (month) (day) (year)

Cemetery or crematory: Naval cemetery

Location: Annapolis, Md

18. Funeral director: B. L. Hopping

Address: Annapolis, Md.

19. 9 3 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 30 1940, at 11 55 p M

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Post Mortem Examination ~~and that I last saw deceased alive on~~ 19

Immediate cause of death: Fractured neck

~~Due to~~ Crushed Chest (right side)

~~Due to~~ Internal injuries

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: 8/30/40

Where did injury occur? Neems Creek (City or town) A.A. (County) Md (State)

Injured at home, farm, industry, public place (where?): Neems Creek Rd & Revell St

Means of injury: Automobile & bus collision Injured at work? No

23. SIGNATURE: John M. Claffey Deputy medical examiner M. D. or other

Address: Annapolis, Md. Date signed: 9/3/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 5 1940
BUREAU V. S.

08289

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 2 yrs. 5 mos. 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 541 Hoffman Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ------

3. (a) FULL NAME
ROLAND CARTER

3. (b) Social Security Number
------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	widowed

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1895

8. AGE: Years: 45 Months: Unknown Days: If less than one day: ..... hrs. ..... min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: General

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Lucy Carter
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Crownsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9/3-40 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md.

18. Funeral director: Supt

Address

19. 9/3-40 (Date rec'd by registrar) 19 E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 29th 19 40 at 9:15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10th 19 38, to August 29 19 40 and that I last saw him alive on August 29th 19 40

Immediate cause of death	DURATION
General paralysis of the insane	
Due to	
Due to Lues	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: -------

Date of op.

Autopsy results: -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: --- Date of

Where did injury occur? ----- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ----

Means of injury Injured at work? -----

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Md. Date signed: 8/29/40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 5 1940

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08290

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Crownsville State Hospitals
How long in hospital or institution? 20 yrs. 10 mos. 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1528 Druid Hill Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: ------

3. (a) FULL NAME
RINGGOLD CLARK

3. (b) Social Security Number
---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	black	single

6.(b) Name of husband or wife: --------
6.(c) If alive, give age: --- years
7. Birth date of deceased (mo., day, yr.): 1886

8. AGE: Years: 54 Months: Unknown Days: If less than one day: ..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: -----
FATHER
12. Name: Unknown
13. Birthplace: Unknown
MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown
16. Informant: Hospital Records
Address: Crownsville, Maryland
17. Burial (Burial, cremation, or removal, Which?) Date thereof: 8-7-1940 (month) (day) (year)
Cemetery or crematory: Mt Auburn Cmty
Location: Balto Md
18. Funeral director: George T. A. Gibson Sr
Address: 1735 Druid Hill Ave
19. 8-5-40 (Date rec'd by registrar) 19..... E. T. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 5th 19 40, 3:50A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 22nd 19 19, to Aug. 5th 19 40
and that I last saw him alive on August 5th 19 40

Immediate cause of death	DURATION
Chronic myocarditis	
Due to	
Due to	
Other conditions: Syphilis	

(Include pregnancy within 3 months of death)
Major findings of operations: -----
Date of op.
Autopsy results: -----
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ----- Date of
Where did injury occur? ------ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): -------
Means of injury: Injured at work? -----

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Md. Date signed: 8/5/40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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AUG 15 19[illegible]
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-a

08291

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:

County Anne Arundel

City or town Ben Field

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crain Heighway

Stay in hospital or inst. (yrs., or mos., or days) 25 yrs

Stay in this community (yrs., or mos., or days) 25 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Anne Arundel

City or town Ben Field Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Crain Heighway, Millersville P.O.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Jacobs Maurice Dicus Jr

3. (b) Social Security Number 705-07-7857

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of ~~husband~~ or ~~wife~~ Elver Ann Dicus

6(c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) May 3 1890

8. AGE: Years 50 Months 3 Days 8 If less than one day ___ hrs. ___ min.

8. Birthplace Balto (Town, county, and state)

10. Usual occupation Conductor B & O.

11. Industry or business

FATHER 12. Name Jacobs M Dicus

13. Birthplace Md

MOTHER 14. Maiden name Margaret J Merdith

15. Birthplace Del

16. Informant Mrs Elver Ann Dicus

Address Crain Highway.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 15-40 (month) (day) (year)

Cemetery or crematory Baldwin Mem Church Cemetery

Location Millersville A A Co Md

18. Funeral director William M Mareck

Address 715 Light St

19. Aug 13 1940 (Date rec'd by registrar) Mrs DeAlba Dep Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 1940, at 12 10 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/7/40 19 to 8/11/40 19 and that I last saw him alive on 8/10/40 19

Immediate cause of death Coronary Thrombosis

Due to

Due to Chronic Interst. Nephritis, Chronic Endocarditis, Hypertension, Arterio Sclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy No

DURATION

Unknown

Unknown

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John J Alexander M. D. or other

Address Glen Burnie Date signed

RECEIVED
AUG 16 1940
BUREAU V. C.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55-8)

08292

CERTIFICATE OF DEATH

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel.

City or town: Linthicum Hts.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Cleveland Road.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 15 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland. County: Anne Arundel

City or town: Linthicum Hts. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Cleveland Road.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: No.

3. (a) FULL NAME: Otis Kirk Dodson.

3. (b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White	Married.

6 (b) Name of husband or wife: Mrs. Alice M. Dodson.

6(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): Sept 14, 1886.

8. AGE:

Years	Months	Days	If less than one day
53	11	2	hrs. ___ min.

9. Birthplace: Avalon, Virginia
(Town, county, and state)

10. Usual occupation: Stationary Engineer

11. Industry or business: Board of Education of Balt City

FATHER
12. Name: James Dodson.
13. Birthplace: Virginia

MOTHER
14. Maiden name: Jenia Lewis.
15. Birthplace: Virginia.

16. Informant: Mrs. Alice M. Dodson.
Address: Linthicum Hts. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 19, 1940 (month) (day) (year)

Cemetery or crematory: London Park

Location: Balto. Md.

18. Funeral director: George W. Little

Address: 2700 Edmondson Ave

19. 16 Aug 1940 (Date rec'd by registrar) Caldwell Woodruff Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 16. 1940, at 5½ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1938, to Aug 16 1940, and that I last saw h-- alive on Aug 15 1940.

	DURATION
Immediate cause of death: Carcinoma of the Liver & Lungs	18 months
Due to: Carcinoma of Axillary Glands	2½ yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings: Removal of Glands of neck.
Of operations: about 2 years ago.
Of autopsy: none

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: James S. Billings M.D.
M. D. or other

Address: Glen Burnie. Md. Date signed: Aug 18, 1940

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AUG 23 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 21 08293

1. PLACE OF DEATH:

County: A. A.

City or town: Annapolis (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Emergency Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: A. A.

City or town: Annapolis Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Warren Garner Estep

3. (b) Social Security Number

4. Sex: Male

5. Color or race: Colored

6. (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept. 19 1924

8. AGE: Years: 15 Months: 11 Days: 22 If less than one day hrs. min.

9. Birthplace: Calvert Co. (Town, county, and state)

10. Usual occupation: School boy.

11. Industry or business

FATHER: 12. Name: Eugene Gantt.

13. Birthplace: A. A.

MOTHER: 14. Maiden name: Mary Randall

15. Birthplace: Calvert Co.

16. Informant: Mary Watkins

Address: Mitchell, A. A. Co. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 31 40 (month) (day) (year)

Cemetery or crematory: Friendship Cem.

Location: Friendship Md

18. Funeral director: J. B. Johnson

Address: Annapolis

19. 8 31 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 28 1940, at 5:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 22 1940, to Aug. 28, 1940, and that I last saw him alive on Aug. 28 1940.

Immediate cause of death: Intestinal Obstruction — DURATION: 5 days

Due to: Gangrene of a loop of Ileum — 5 days

Due to: Strangulation — 5 days

Other conditions: Strangulated Rt. Inguinal Hernia — 6 days

(Include pregnancy within 3 months of death)

Major findings:

Of operation: (1) Operation for Strangulated Hernia

Of autopsy: (2) Operation for release of obstruction

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Albert L. Anderson M. D. or other

Address: Annapolis, Md. Date signed: 8/28/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08294

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? since Aug. 9, 1937

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1625 Westwood Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Blanche EVANS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	negro	married

6.(b) Name of husband or wife: Roscoe Evans
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1890

8. AGE: Years: 50 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Sandy Spring, Md.
(Town, county, and state)

10. Usual occupation: housework

11. Industry or business: —

FATHER
12. Name: John Cole
13. Birthplace: ? Md.

MOTHER
14. Maiden name: Perryanna Budd
15. Birthplace: ? Md

16. Informant: Hospital record
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 4-1940 (month) (day) (year)
Cemetery or crematory: Mt. Olivet Cemetery, Maryland
Location: Upper Marlboro, Maryland

18. Funeral director: Joseph A. Lively
Address: 402 North Mount St Baltimore Md

19. 2 Sept 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 31 1940 at 2.25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 9, 1937 to August 31 1940
and that I last saw h. alive on August 31 1940

	DURATION
Immediate cause of death: tuberculosis of the respiratory system	more than 2 months
Due to:	
Due to:	
Other conditions: schizophrenia, katatonic type	3 years

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Parkville Md. Date signed: 31 Aug '40

RECEIVED
SEP 5 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08295

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 0

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 191 Clay St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: 5 mos. foetus still-born Fox

3. (b) Social Security Number

4. Sex: female

5. Color or race: negro

6. (a) Single, married, widowed, or divorced: —

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug. 1. 1940

8. AGE: Years | Months | Days | If less than one day: hrs. 0 min.

9. Birthplace: Annapolis Md
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: Cotee Fox.
13. Birthplace: Mississippi.

MOTHER
14. Maiden name: Nellie Simms.
15. Birthplace: Annapolis. Md

16. Informant: Nellie Simms

Address: Annapolis. Md

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof: 8/2/40 (month) (day) (year)

Cemetery or crematory: Brewer Hill

Location: 1 N Washington rd out sid Annapolis Md

18. Funeral director: Chas. H. Alexander

Address: 43-45 northwest st. Annapolis Md.

19. 8/2 1940. (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 1 1940, at 4 A M

21. I CERTIFY that death occurred on the date above stated; ~~that attended deceased from~~ Post-mortem examination.

~~and that I last saw him alive on~~ Aug 1 1940

Immediate cause of death: Still-birth

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations — —

Of autopsy — —

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John M. Claffey Deputy medical examiner M. D. or other

Address: Annapolis. Md Date signed 8/1/40

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

08296

CERTIFICATE OF DEATH

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Glen Burnie

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Quarterfield Road.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 22 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A.A.

City or town: Glen Burnie Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Quarterfield Rd.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: None

3. (a) FULL NAME: Joshua Grant Gaither

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6 (b) Name of husband or wife: Emma Gaither

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 19, 1875.

8. AGE: Years: 65 | Months: 3 | Days: 27 | If less than one day: hrs. min.

9. Birthplace: Prince Geo. County, Md

(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Farming.

FATHER

12. Name: Benj. Gaither

13. Birthplace: Maryland.

MOTHER

14. Maiden name: Mina Willis Bellmare

15. Birthplace: Maryland.

16. Informant: Aubrey Gaither

Address: Glen Burnie, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 19 1940 (month) (day) (year)

Cemetery or crematory: Mt. Calvary Cem. A.A. Co. Md.

Location:

18. Funeral director: Mrs. Frances A. Beverley

Address: 578 N. Biddle St.

19. Aug 17 1940 (Date rec'd by registrar) M. D'Alla Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 16, 1940, at 1:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15, 1940, to Aug 16, 1940. and that I last saw him alive on Aug. 14, 1940.

Immediate cause of death	DURATION
Cerebral hemorrhage	4 days
Due to Arteriosclerosis	1 year
Due to	
Other conditions Previous cerebral hemorrhage	8 mos.

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Harry M. Moore M.D.

M. D. or other

Address: Glen Burnie Md. Date signed: Aug 16 1940.

RECEIVED
SEP 5 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(97)

08297

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 7 yrs. 2 mos. 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City (If outside city or town limits, write RURAL and give nearest town)

Street No.: 543 Bloom Street (If rural, give LOCATION)

2.(a) If veteran, name war: ----------

3. (a) FULL NAME: JAMES GARNER #2

3. (b) Social Security Number: ------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife: ----------

6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1886

8. AGE: Years: 54 Months: Unknown Days: If less than one day: ..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: -----

FATHER
12. Name: James Wilson Garner
13. Birthplace: Unknown

MOTHER
14. Maiden name: Ruby
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: 8/29/40 (month) (day) (year)

Cemetery or crematory: St. Peter's Cemetery

Location: Baltimore, Maryland

18. Funeral director: Thomas Kelson

Address: 1303 Presstman St., Baltimore, Maryland

19. 8/27-40 (Date rec'd by registrar) 19 ..... E.T. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 26th 19 40 at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 30th 19 33, to Aug. 26 19 40 and that I last saw him alive on August 26th 19 40

Immediate cause of death: Arteriosclerosis

Due to:

Due to:

Other conditions: ------

(Include pregnancy within 3 months of death)

Major findings of operations: -----

Date of op.

Autopsy results: ----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ----- Date of

Where did injury occur? ----- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ------

Means of injury: Injured at work? -------

23. SIGNATURE: Herb P. Amelgrodz M. D. or other

Address: Crownsville, Md. Date signed: 8/26/40

RECEIVED
AUG 30 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (308)

08298

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 1 month, 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1005 West Lanvale Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ----------

3.(a) FULL NAME ERNEST GIBSON

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	black	married

6.(b) Name of ~~husband~~ or wife: Ella M. Gibson

8.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1883

8. AGE: Years: 57 Months: Unknown Days: If less than one day: ..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Wagon-driver

11. Industry or business: Unknown

FATHER
12. Name: Ernest Gibson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Annie (Unknown)
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 26 1940 (month) (day) (year)

Cemetery or crematory: Mt. Auburn

Location: Balto. Md.

18. Funeral director: Mrs Frances A. Hemsley

Address: 578 W. Biddle St. Balto Md

19. 8/22/40 19 (Date rec'd by registrar) E F Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 22nd 1940, at 7:20P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 11th 1940, to Aug. 22nd 1940 and that I last saw h..... alive on August 22nd 1940

Immediate cause of death: Cerebral hemorrhage — DURATION

Due to:

Due to:

Other conditions: General paralysis of the insane
(Include pregnancy within 3 months of death)

Major findings of operations: -----

Date of op.

Autopsy results: -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: ------ Date of

Where did injury occur? ------ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ------

Means of injury: Injured at work? ------

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Md. Date signed: 8/22/40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 5 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

CERTIFICATE OF DEATH

Reg. Dist. No. 21 08299

1. PLACE OF DEATH:

County: AA.

City or town: Annapolis. Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Emergency Hospital.

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: A.A.

City or town: Eastport Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 1131 Bayridge Road
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Baby Boy Grimes.

3. (b) Social Security Number: None

4. Sex: m

5. Color or race: wh

6. (a) Single, married, widowed, or divorced: —

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug 10 – 1940

8. AGE: Years | Months | Days | If less than one day: 0 hrs. 0 min. stillbirth

9. Birthplace: Annapolis. Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Walter S. Grimes
13. Birthplace: Toboro, N. C.

MOTHER
14. Maiden name: Daisy May. Bick
15. Birthplace: Speed, N.C.

16. Informant: Walter S. Grimes
Address: 1131 Bayridge Road Eastport Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Aug 12 1940 (month) (day) (year)

Cemetery or crematory: St. Stephens

Location: Millersville. Md.

18. Funeral director: B.L.Hopping
Address: Annapolis, Md.

19. 8/2 1940 (Date rec'd by registrar) J J Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 10 1940, at 10:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 ,
and that I last saw h alive on 19 .

Immediate cause of death: intercranial hemorrhage

Due to: prolonged labor

Due to: arrested transverse position

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: S. Borrusch. M.D.
M. D. or other
Address: Hotel Md. Bldg. Annapolis Md Date signed 8/10/40

RECEIVED
SEP 5 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-B)

08300

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:

County Anne Arundel

City or town Galesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Galesville
(if outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME Jennie Hazard

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife John Frank Hazard

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 3 1859

8. AGE:

Years	Months	Days	If less than one day
80	10	18	..... hrs. ..... min.

9. Birthplace Mayo, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Richard Joyce
13. Birthplace Md

MOTHER
14. Maiden name Julia Ford
15. Birthplace Md.

16. Informant Mrs Warren Hazard

Address Galesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8 (month) 23 (day) 40 (year)

Cemetery or crematory Quaker Burial Ground

Location Galesville, Md.

18. Funeral director T. A. Hardesty & Son

Address Galesville Md

19. 8-22 (Date rec'd by registrar) 1940 W. R. Clayton Dep Heal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21 1940, at 10 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 5 1940, to Aug 21 1940 and that I last saw her alive on Aug 21 1940

Immediate cause of death Carcinoma of uterus with generalized metastases

Due to General arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel Bonsack MD
M. D. or other

Address Annapolis Md Date signed Aug 22 1940

RECEIVED
SEP 7 1940
BUREAU V. S.

Dr. Klevans

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157)

CERTIFICATE OF DEATH

08301

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A(5) (T)

1. PLACE OF DEATH:
County A. A.
City or town Annapolis
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Emergency Hospital
Stay in hospital or inst. (yrs., or mos., or days) 6 days
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A. A.
City or town Annapolis Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Margrett Ann Jacobs

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Fem	Colored	single

6 (b) Name of husband or wife —

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) June 27 1940

8. AGE: Years | Months: 1 | Days: 18 | If less than one day: ____ hrs. ____ min.

9. Birthplace Brownswood (Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER
12. Name Vernard Jacobs
13. Birthplace Near Annapolis

MOTHER
14. Maiden name Arnetta Hebron
15. Birthplace Brownswood

16. Informant Arnetta Jacobs
Address Brownswood

17. Burial (Burial, cremation, or removal, Which?) Date thereof Aug 15 1940 (month) (day) (year)
Cemetery or crematory Brewers Hill
Location Annapolis

18. Funeral director J. B. Johnson
Address Annapolis

19. 8/15/40 (Date rec'd by registrar) J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 13 1940, at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 7 1940, to Aug 13 1940, and that I last saw h alive on Aug 12 1940.

Immediate cause of death	DURATION
Premature birth (7 mo)	
Due to Unknown cause.	
Due to No other apparent illness	
Other conditions Poor feeding case.	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Manuel F. Klevans, Md
M. D. or other
Address 31 Southgate Ave Date signed 8/14/40

RECEIVED
SEP 5 1940
BUREAU V. S.

08302 *

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(8)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Aa Co Md

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? —

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: — County: —

City or town: —

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME none Jones

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
unknown	w	—

6.(b) Name of husband or wife: none

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 13/40

8. AGE: Years | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: Annapolis Md (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER

12. Name: George C. Jones

13. Birthplace: Annapolis Md

MOTHER

14. Maiden name: Charlotte Esther Frank Cin

15. Birthplace: Annapolis Md

16. Informant: Mrs Charlotte E. Jones

Address: Annapolis Md

17. (Burial, cremation, or removal. Which?) Date thereof ..... (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director: Foxtus Cost nothing to bury

Address

19. Aug 17 1940 (Date rec'd by registrar) J. G. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/13/40 19..., at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Miscarriage

Due to: About 3 wks or 4 wks

Due to: Advanced. No foetus

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Oliver Pierce M. D. or other

Address: Annapolis Md Date signed: 8/14/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 5 1940
BUREAU V. S.

VS A15 (T) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

08303

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Old Glory Beach
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 2 hours

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 610 E. 27th St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Edward Lawson

3. (b) Social Security Number

4. Sex: male

5. Color or race: white

6.(a) Single, married, widowed, or divorced: single

6.(b) Name of husband or wife:

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 4, 1893

8. AGE: Years: 47 Months: 1 Days: 0 If less than one day ..... hrs. ..... min.

9. Birthplace: Baltimore Md
(Town, county, and state)

10. Usual occupation: Produce

11. Industry or business: Produce wholesale

FATHER
12. Name: Henry Lawson
13. Birthplace: Md.

MOTHER
14. Maiden name: Elmora Berner
15. Birthplace: Md.

16. Informant: Robert Lawson

Address: 610 E. 27th St Baltimore Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 6 1940 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location:

18. Funeral director: Wm Cook

Address: 1217 St Paul St

19. 8-4 1940 (Date rec'd by registrar) L. A. Breit Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 4 1940, at 7 30 A M

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post mortem examination ~~and that I last saw h.....alive on~~ Aug. 4 1940

Immediate cause of death: Drowning

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 8/4/40

Where did injury occur? Stony Creek (City or town) AA (County) Md (State)

Injured at home, farm, industry, public place (where?) Old Glory Beach

Means of injury: Drowning Injured at work? No

23. SIGNATURE: John M. Claffy Deputy medical examiner M. D. or other

Address: Annapolis, Md. Date signed: 8/4/40

RECEIVED
AUG 9 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

08304

Reg. Dist. No. 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Woodlawn Beach
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Washington D C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5315 13th St. N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME Phyllis Grace Lewis

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 20th 1908

8. AGE: Years	Months	Days	If less than one day
31	11	14	hrs. min.

9. Birthplace: Baltimore Md. (Town, county, and state)
10. Usual occupation: Asst.
11. Industry or business: Insurance
FATHER 12. Name: Earl Thompson Lewis
13. Birthplace: Washington D C.
MOTHER 14. Maiden name: Nellie Ann Pepper
15. Birthplace: Washington D.C.
16. Informant: Nellie Pepp
Address: 5315-13th St. N.W. Washington D.C.
17. Burial (Burial, cremation, or removal? Which?) Date thereof: Aug. 6th 1940 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cem.
Location: Washington D. C.
18. Funeral director: Shee S. H. Higgs Co.
Address: 2901-14th St N.W. Washington D.C.
19. Aug 5th 1940 (Date rec'd by registrar) J. J. McGrath Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 3 1940, at 7:45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Death inquiry, to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Drowning, accidental	
Due to	
Due to	
Other conditions: Acute alcoholism	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results: as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: accident Date of
Where did injury occur? Woodland Beach, Anne Arundel Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): public place
Means of injury: drowning Injured at work?

23. SIGNATURE: H. L. Wallenmeyer, M.D.
M. D. or other
Address: City morgue, Baltimore Date signed: 8-4-40

RECEIVED
SEP 5 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (69)

CB

08305

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:

County Anne Arundel

City or town Jessup, Md.
(If outside city or town limits, write RURAL NEAR and give town)

~~Street address, hospital, or~~ institution:
Maryland House of Correction

Stay in ~~hospital~~ or inst. (yrs., or mos., or days) 26 Days

Stay in this community (yrs., or mos., or days) XX

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State New York County Greene

City or town Catskill Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR No

3. (a) FULL NAME
CARL LEZETTE

3. (b) Social Security Number

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Unknown

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): March 20th, 1894

8. AGE:

Years	Months	Days	If less than one day
46	5	4	19 hrs. 35 min.

9. Birthplace: Catskill, Greene County N.Y.
(Town, county, and state)

10. Usual occupation: Shoemaker

11. Industry or business

FATHER
12. Name: John Lezette
13. Birthplace: (Dead)

MOTHER
14. Maiden name: Martha Lezette (Hornbeck)
15. Birthplace: (Dead)

16. Informant: Recorder Md House of Correction
Address: Jessups, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 3, 1940 (month) (day) (year)

Cemetery or crematory: Cherry Hill

Location: Jessup Md

18. Funeral director: H L Collins

Address: Jessup Md

19. Sept 3 1940 (Date rec'd by registrar) Clara M Hasluft Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25th ~~1894~~ 1940 19 ____, at 7.35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 31st, 1940, to Aug. 25th 1940, and that I last saw him alive on August 25th 1940.

Immediate cause of death	DURATION
Myocarditis	??
Due to Pellagra	??
Due to Bronchiectasis	??
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ____ Injured at work?

23. SIGNATURE M. R. Turnpt, M.D. M. D. or other

Address Jessup, Maryland Date signed 8-26-40

RECEIVED
OCT 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08366

Reg. Dist. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel
City or town Sothian (Rural)
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: —
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) Stillborn

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Stillborn McGhee

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	Colored	Stillborn

6 (b) Name of husband or wife Stillborn
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 17 1940

8. AGE: Years | Months | Days | If less than one day hrs. min.
Stillborn

9. Birthplace Sothian Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Thomas McGhee
13. Birthplace Halifax, Va

MOTHER
14. Maiden name Rebecca Pratt
15. Birthplace Fairhaven, Md

16. Informant Thomas McGhee
Address Sothian

17. Burial Date thereof Aug 17 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Cemetery
Location Friendship

18. Funeral director Thomas McGhee
Address Lothian Md.

19. Aug 17 1940 H. R. Clayton
(Date rec'd by registrar) Dep Mil Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 17 1940, at 4:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19, to 19,
and that I last saw h alive on 19.

Immediate cause of death	DURATION
Stillborn	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy No

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) No
Means of injury None Injured at work? —

23. SIGNATURE James E. Spencer
M. D. or other
Address Upper Marlboro Md Date signed 8/17/40

RECEIVED
SEP 7 1940
BUREAU V. S.

08307

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (114C)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1632 Gilmor Street
(If rural, give LOCATION)

2.(a) If veteran, name war: -------

3. (a) FULL NAME

ALBERT MEYERS

3. (b) Social Security Number

---

4. Sex: MALE ~~33~~

5. Color or race: BLACK ~~male~~

6.(a) Single, married, widowed, or divorced: ~~black~~- single

6.(b) Name of husband or wife: ------

6.(c) If alive, give age: ------ years

7. Birth date of deceased (mo., day, yr.): 1907

8. AGE: Years: 33 | Months: Unknown | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: General

FATHER
12. Name: Albert Meyers
13. Birthplace: Virginia

MOTHER
14. Maiden name: Florence Anna (Unknown)
15. Birthplace: Virginia

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal, Which?) Date thereof: 9/6-40 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md

18. Funeral director: Supt

Address

19. 9-6-40 19 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 30th 1940, at 1:40P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 16th 1940, to Aug. 30 1940 and that I last saw him alive on Aug. 30th 1940

Immediate cause of death: Aspiration pneumonia

Due to:

Due to:

Other conditions: Pulmonary gangrene

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: ------

Date of op.

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ----- Date of:

Where did injury occur? ----- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -----

Means of injury: Injured at work? ------

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Md. Date signed: 8/30/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 5 1940
BUREAU V. S.

08308

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-E)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 2 yrs. 2 mos. 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1629 E. Madison Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ------

3. (a) FULL NAME: JANIE MILLS

3. (b) Social Security Number: -------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	black	married

6.(b) Name of husband or ~~wife~~ xx: Unknown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1916

8. AGE: Years	Months	Days	If less than one day
24	Unknown		..... hrs. ..... min.

9. Birthplace: South Carolina
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: ----

FATHER
12. Name: John Bells
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Daisy Shelton
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Aug. 22. 1940 (month) (day) (year)

Cemetery or crematory: Mt. Calvary Cemetery

Location: Anne Arundel County, Md.

18. Funeral director: Joseph G. Locks, Jr.

Address: 1304 N. Central ave. Baltimore

19. 8/19/40 19 E. F. Joyce DL
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 18th 1940, at 11:40P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 6th 1938, to Aug. 18th 1940 and that I last saw her alive on Aug. 18th 1940

Immediate cause of death	DURATION
Pulmonary tuberculosis	
Due to	
Due to	
Other conditions: ------	

(Include pregnancy within 3 months of death)

Major findings of operations: ----

Date of op.

Autopsy results: -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of

Where did injury occur? ------ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ------

Means of injury: Injured at work? -----

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Maryland Date signed: 8/18/40

VS A15 (T) (I) (M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 23 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08309

(183)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Herald Harbor (Severn River)
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: —
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 1625 Monroe St. N.W.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: World War ✓

3. (a) FULL NAME: George Walter Neely

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband ~~or wife~~: Bernetta C. Neely
6(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): Nov. 23, 1902.

8. AGE: Years: 38 | Months: 8 | Days: 12 | If less than one day: hrs. min.

9. Birthplace: Cincinnati, Ohio.
(Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business: American Fork Co.

FATHER
12. Name: not known
13. Birthplace:

MOTHER
14. Maiden name: not known
15. Birthplace:

16. Informant: Mrs. Bernetta C. Neely
Address: 1625 Monroe St. N.W. Wash. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 15, 1940 (month) (day) (year)
Cemetery or crematory: Arlington National Cem.
Location: Wash. D.C.

18. Funeral director: Wm J. Malley
Address: 522-8th St. S.E.

19. 8/11 40 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 11 1940, at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post mortem examination
~~and that I last saw him alive on~~ Aug. 11, 1940

Immediate cause of death	DURATION
Drowning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 8/11/40
Where did injury occur? Herald Harbor (City or town) A.A. (County) Md. (State)
Injured at home, farm, industry, public place (where?): Severn River
Means of injury: drowning Injured at work? no

23. SIGNATURE: John M. Claffy Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed: 8/11/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
AUG 26 1940
BUREAU

Dr. Klawans

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-B)

CERTIFICATE OF DEATH

08310

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 (T)

1. PLACE OF DEATH:
County H. A.
City or town Parole
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Md. County A. A.
City or town Parole Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Catherine Ogle

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Fem	Colrd	married

6 (b) Name of husband or wife Jeremiah Ogle
6(c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) May 5 1873

8. AGE:

Years	Months	Days	If less than one day
67	3	13	hrs. min.

9. Birthplace Waterbury
(Town, county, and state)
10. Usual occupation Housework
11. Industry or business
FATHER 12. Name Nathegrid Jacobs
13. Birthplace Talbot Co Md
MOTHER 14. Maiden name Louisa Hawkins
15. Birthplace Charles Co Md.
16. Informant George N. Jacobs
Address 21 Morris St
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 21 1940 (month) (day) (year)
Cemetery or crematory John Wesley
Location Waterbury, A.A. Co. Md
16. Funeral director J. B. Johnson
Address Annapolis
19. 8/21/1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 18 1940, at noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 5 1940, to Aug. 18 1940, and that I last saw h alive on Aug 18 1940.

	DURATION
Immediate cause of death Probably primary carcinoma of uterus with Cerebral Hemorrhage	24 hrs.
Due to Gen. arterio sclerosis with	
Due to hypertension. Cystitis	
Other conditions At time of death, a huge mass involving all her pelvis organs Prostatic C A bladder Ulcers 8 Mo	

(Include pregnancy within 3 months of death)

Major findings:
Of operations None.
Of autopsy None.

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Maurice J. Klawans, MD
M. D. or other
Address 31 South St Balto Md Date signed 8/19/40

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

08311

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 1 yr. 7 mos. 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Frederick

City or town: Frederick
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 222 Broadway
(If rural, give LOCATION)

2.(a) If veteran, name war: -------

3. (a) FULL NAME: ALICE ONLEY

3. (b) Social Security Number: -------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	widowed

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1873 (?)

8. AGE: Years: 67? Months: Unknown Days: If less than one day: ..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: -----

FATHER
12. Name: Robert Butcher
13. Birthplace: Maryland

MOTHER
14. Maiden name: Elizabeth (Unknown)
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8/28/1940 (month) (day) (year)

Cemetery or crematory: Hope Hill

Location: No. Brickerystown, Md

18. Funeral director: M. R. Etchison & Son

Address: Frederick, Md.

19. 8/26 40 19 (Date rec'd by registrar) E. F. Joyce D.R. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 26th 1940, at 1:40P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 14th 1939, to Aug. 26th 1940 and that I last saw her alive on August 26th 1940

Immediate cause of death	DURATION
Generalized arteriosclerosis	
Due to	
Due to	
Other conditions: Chronic myocarditis	

(Include pregnancy within 3 months of death)

Major findings of operations: ------

Date of op.

Autopsy results: ------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -------- Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ------

Means of injury: Injured at work? -----

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Md. Date signed: 8/26/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 5 1940
BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

08312

CERTIFICATE OF DEATH

Reg. Dist. No. 22

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County A. A. Co

City or town near Woodwardville 2nd

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: —

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant give residence of mother)

State Maryland County A. A. Co

City or town near Woodwardville Ward No. 2nd

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Rd. address Odenton Md

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME William Edward Parker

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Susie Parker

6(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) unknown 1851

8. AGE: Years 89 | Months 7 | Days — | If less than one day — hrs. — min.

9. Birthplace Charlesfield Md. (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Laborer

FATHER 12. Name Frank Parker

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden name unknown

MOTHER 15. Birthplace —

16. Informant Booker Parker

Address Odenton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 7 1940 (month) (day) (year)

Cemetery or crematory Zion Church

Location Anne Arundel Co

18. Funeral director Ridgley & Selby

Address 401 Washington Laurel Md.

19. Sept 2 1940 (Date rec'd by registrar) W. L. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1940 at 9 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 1st 1940, to Aug 30 1940, and that I last saw h— alive on Aug. 29 1940.

Immediate cause of death	DURATION
Myocarditis, Arteriosclerosis	2 Months
Due to	
Due to age	
Other conditions Myocardial degeneration	

(Include pregnancy within 3 months of death)

Major findings: —

Of operations —

Of autopsy —

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE G E Lancaster M D

M. D. or other

Address Bowie Date signed 8-30-40

RECEIVED
SEP 28 1940
BUREAU V. S.

08313

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-2)

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis, Md
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Emergency Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: A. A. Co

City or town: Galesville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: none

3. (a) FULL NAME: Lois Emma Peake

3. (b) Social Security Number: none

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	W	W

6 (b) Name of husband or wife: J. Millard Peake

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Jan 29 1864

8. AGE:

Years	Months	Days	If less than one day
76	6	28	hrs. min.

9. Birthplace: A A Co.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Wm. Wesley
13. Birthplace: md.

MOTHER
14. Maiden name: Mary E Cooley
15. Birthplace: md.

16. Informant: Walter Peake
Address: Galesville, md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 29 40 (month) (day) (year)

Cemetery or crematory: Quaker Cemetery

Location: Galesville, md

18. Funeral director: T. A. Hardesty & Son
Address: Galesville, md

19. 8-28 19 40 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 27 1940, at 3 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 20 1940, to Aug 27 1940, and that I last saw her alive on Aug 27 1940.

Immediate cause of death	DURATION
Cerebral Hemorrhage	8/20/40
Due to Arteriosclerosis	
Due to	
Other conditions: Possibility Coronary Thrombosis (Include pregnancy within 3 months of death)	8/20/40

Major findings:
Of operations
Of autopsy: None.

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ____ Injured at work?

23. SIGNATURE: Marvin F. Klawans, md M. D. or other
Address: 31 Smithgate av Date signed: 8/28/40

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 5 1940
BUREAU V. S.

VS A15 (T) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183) 08314

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Shady Side
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Virginia County: Arlington
City or town: ~~[illegible]~~ Arlington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4440 N. Glebe Road
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: George H. Robertson

3. (b) Social Security Number:

4. Sex: male
5. Color or race: white
6.(a) Single, married, widowed, or divorced: single
6.(b) Name of husband or wife: — —
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Aug. 21. 1913

8. AGE: Years: 26 Months: 11 Days: 17 If less than one day ..... hrs. ..... min.

9. Birthplace: Great Falls, Maryland
(Town, county, and state)
10. Usual occupation: Fireman
11. Industry or business: Arlington County Dept.

FATHER
12. Name: George P. Robertson
13. Birthplace: Rockville Md.

MOTHER
14. Maiden name: Harriett Elliott
15. Birthplace: Walkers Chapel, Va.

16. Informant: Samuel T. Robertson
Address: Bethesda, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 5 - 1940 (month) (day) (year)
Cemetery or crematory: Arlington
Location: Arlington, Va.

18. Funeral director: E. H. Ives
Address: Arlington Va.

19. Aug 4 1940 (Date rec'd by registrar) O B Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 4 1940, at 8:50 A.M.

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Post-mortem examination 19 ~~and that I last saw him alive on~~ Aug 4 1940

Immediate cause of death: Drowning — DURATION
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 8/2/40
Where did injury occur? Shady Side Aft. Md (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): West River
Means of injury: drowning Injured at work? no

23. SIGNATURE: John M. Claffy Deputy Medical Examiner M. D. or other
Address: Annapolis, Md. Date signed: 8/4/40

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore 17-9 Reg. Dist. No. 21

CERTIFICATE OF DEATH

08315

1. PLACE OF DEATH:

(a) County Anne Arundel

(b) City or town Green Haven (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: P.O. Pasadena

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 10 yrs

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County A A.

(c) City or town Green Haven (If outside city or town limits, write RURAL and give town)

(d) Street No. P.O. Pasadena (If rural give location)

(e) If foreign born, how long in U. S. A.? ____ years

3 (a) **FULL NAME** Regina Rode

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex: fem

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Gottlieb Rode

6. (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): June 8, 1866

8. AGE: Years: 74 Months: I Days: I4 If less than one day ____ hr. ____ min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Benjamin Rode

13. Birthplace: Baltimore, Md.

MOTHER

14. Maiden Name: unknown

15. Birthplace

16 (a) Informant: Harry Rush

(b) Address: Green Haven, Md.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Aug. 6, 40 (month) (day) (year)

(c) Cemetery or crematory: Mt. Carmel Cem.

Location: Baltimore

18 (a) Funeral director: Wm. Cook

(b) Address: I2I7 St. Paul st.

19 (a) 8-4-40 (Date rec'd by registrar) (b) L. A. Brent Registrar

MEDICAL CERTIFICATION

20. Date of death August 4 1940, at I.I5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1938, to Aug. 4 1940, and that I last saw him alive on Aug. 3 1940.

Immediate cause of death	Duration
Pulmonary carcinoma	3 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature L. A. Brent, M. D. (M. D. or other)

Address Pasadena, Md. Date signed 8-4-40

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 10 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

08316

Reg. Dist. No. 21

VS A15 (T)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Chesapeake Bay near Pinehurst
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Fullerton
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Belair Road.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME John G. Rohe

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Elizabeth Rohe
6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): July 9. 1900

8. AGE: Years	Months	Days	If less than one day
40	1	8	hrs. min.

9. Birthplace: Fullerton (Town, county, and state)
10. Usual occupation: Proprietor
11. Industry or business: Tavern Keeper
FATHER 12. Name: Valentine Rohe
13. Birthplace: Baltimore County
MOTHER 14. Maiden name: Mary Miller
15. Birthplace: Baltimore County
16. Informant: Mrs. Elizabeth Rohe
Address: Fullerton. Balto Co. Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 18 40 (month) (day) (year)
Cemetery or crematory: Parkwood
Location: Balto City
18. Funeral director: Lassahn F. St.
Address: 7401 Belair Rd.
19. Aug. 17 1940 L. A. Bleis (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 17 1940 at 11 A M
21. I CERTIFY that death occurred on the date above stated; ~~[illegible]~~ from
Post-mortem to Examination
~~[illegible]~~ Aug. 17 1940

Immediate cause of death	DURATION
Drowning.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accidental Date of 8/14/40.
Where did injury occur? Near Pinehurst (City or town) A.A. (County) Md (State)
Injured at home, farm, industry, public place (where?): Chesapeake Bay
Means of injury: drowning. Injured at work? no

23. SIGNATURE: John M. Caffy Deputy medical Examiner (M. D. or other)
Address: Annapolis Md Date signed: 8/17/40

RECEIVED
AUG 22 1940
BUREAU V. S.

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (93d)

Reg. Dist. No. 23

08317

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County A. A.

(b) City or town Linthicum, Md. (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Andover Rd

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 14 yrs

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md (b) County A. A.

(c) City or town Linthicum Md (If outside city or town limits, write RURAL and give town)

(d) Street No. Andover Rd. (If rural give location)

(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME Marie Matilda M Joan Suffner Schaefer (Nee Sufner)

3 (b) If veteran, name war None

3 (c) Social Security No. None

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Clarence Wm Schaefer

6. (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Dec. 27 - 1889

8. AGE: Years 50 Months 7 Days 23 If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual occupation Hw.

11. Industry or business Own Home

FATHER
12. Name Louis Suffner
13. Birthplace Germany

MOTHER
14. Maiden Name Matilda Wagner
15. Birthplace Germany

16 (a) Informant Clarence Wm Schaefer
(b) Address Linthicum, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 23, 1940 (month) (day) (year)
(c) Cemetery or crematory New Cathedral.
Location Baltimore, Md.

18 (a) Funeral director Thomas W. Swigleton
(b) Address Glen Burnie, Md.

19 (a) Aug 22/40 (Date rec'd by registrar) (b) McDe Alba Dep Registrar

MEDICAL CERTIFICATION

20. Date of death Aug. 20 1940, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1936, to Aug. 20 1940, and that I last saw him alive on Aug. 20 1940.

Immediate cause of death	Duration
Cardio Vascular Disease	2 yrs.
Due to Hypertension	5 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Chas. L. Bell, Jr. MD. (M. D. or other)

Address Linthicum Md Date signed Aug. 20. 1940

RECEIVED
SEP 5 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

08318

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1. PLACE OF DEATH (1312)

County A. A. County Maryland Registration Dist. No. 25

Village or City Brooklyn No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Celestine Schiren

(a) Residence: No. Church St & Fischell Ave St. Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*)
Female	White	Married

5a. If married, ~~widowed~~, or ~~divorced~~ HUSBAND of (or) WIFE of John Schiren

6. DATE OF BIRTH (month, day, and year) Dec 27 1878

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	7	5	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Housewife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Baltimore (State or country) Maryland

FATHER

13. NAME Eppolete Affayroux

14. BIRTHPLACE (city or town) (State or country) France

MOTHER

15. MAIDEN NAME Martha

16. BIRTHPLACE (city or town) (State or country) England

17. INFORMANT John Schiren (Address) Church St & Fischel Ave

18. BURIAL, CREMATION, OR REMOVAL GLEN HAVEN MEMORIAL CEMETERY A.A. County Aug 3, 1940

19. UNDERTAKER Robt C & B. M. Walters (Address) Pratt & Stricker Sts - Balto Md

20. FILED Aug 2, 1940 Ida M. Whitam Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH August (Month) 1st (Day) 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from June 10, 1940, to Aug 1, 1940

I last saw her alive on Aug 1st, 1940; death is said to have occurred on the date stated above, at 1:30 P. m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Uremia	
Other **Contributory Causes** of importance:	
Hypertension	
Chronic nephritis	

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of Injury

24. Was disease or Injury in any way related to occupation of deceased?

If so, specify

(Signed) Samuel Rubin M. D.

(Address) 203 Patapsco Ave

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

RECEIVED
AUG 3 1940
BUREAU V. S.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

08319

Reg. Dist. No. 2-3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Anne Arundel

City or town Point Pleasant.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Just arrived.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1649 Hanover St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Elizabeth Singleton.

3.(b) Social Security Number 220-01-1523

4. Sex: female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 1- 1920

8. AGE: Years: 19 Months: 8 Days: 10 If less than one day ..... hrs. ..... min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual occupation: Operator

11. Industry or business: National Enameling & Stamping Co

FATHER

12. Name: Howard C. Singleton

13. Birthplace: Hartford Co Md.

MOTHER

14. Maiden name: Caroline Lulie

15. Birthplace: Baltimore, Md

16. Informant: Mr. Howard C Singleton

Address: 1649 Hanover St Balto. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 14-1940 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Anne Arundel Co. Md.

18. Funeral director: Thomas W Singleton

Address: Glen Burnie Md.

19. Aug 14 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 11. 1940, at 4 15 P M

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post mortem examination. ~~and that I last saw ... alive on~~ Aug 11 1940.

Immediate cause of death	DURATION
Drowning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: / Date of op. /

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 8/11/40

Where did injury occur? Marley H.R. Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Point Pleasant Beach

Means of injury drowning Injured at work? No

23. SIGNATURE: John M Claffy Deputy medical examiner. M. D. or other

Address: Annapolis Md Date signed 8/11/40

RECEIVED
AUG 30 1940
BUREAU V. S.

08320

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs, 5 mos, 6 days

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 6 yrs, 5 mos, 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Monkton
(If outside city or town limits, write RURAL and give nearest town)

Street No. ..... (If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME: Samuel H. Stevenson

3. (b) Social Security Number

4. Sex: Male

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1876

8. AGE: Years: 64 | Months: unknown | Days: | If less than one day ..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Drayman.

11. Industry or business

FATHER
12. Name: Edward Stevenson - deceased
13. Birthplace: unknown.

MOTHER
14. Maiden name: Sarah —
15. Birthplace: unknown.

16. Informant: Hospital Records.
Address: Crownsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9-2-40 (month) (day) (year)

Cemetery or crematory: Mt Auburn

Location: Balto City

18. Funeral director: Mrs Frances H Hensley.
Address: 578 W. Biddle St Balto Md

19. 8/29/40 19 ..... (Date rec'd by registrar) E F Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 29 1940, at 4:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 22 1934, to August 29 1940 and that I last saw him alive on August 29 1940

Immediate cause of death: Chronic myocarditis.

Due to .....

Due to .....

Other conditions .....
(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: —

Date of op. .....

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of .....

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? —

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Md. Date signed: 8/29/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

08321

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mts

Hospital, institution, or street address where death occurred:

A. A. Co. Home for Aged

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Eastport (If outside city or town limits, write RURAL and give nearest town)

Street No. Foot of Fifth St. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME James G. Sullivan

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 19th 1863

8. AGE: Years 77 | Months 3 | Days 3 + | If less than one day: hrs. min.

9. Birthplace: A. A. Co. Md. (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business:

FATHER 12. Name: James Sullivan

FATHER 13. Birthplace: A. A. Co. Md.

MOTHER 14. Maiden name: Unknown

MOTHER 15. Birthplace: Unknown

16. Informant: John Davis

Address: Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 21st 1940 (month) (day) (year)

Cemetery or crematory: St Anns

Location: Annapolis Md.

18. Funeral director: John M. Taylor

Address: Annapolis Md.

19. 8-21 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 19 1940 at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 23 1940, to Aug 17 1940 and that I last saw him alive on Aug 17 1940

Immediate cause of death	DURATION
Arteriosclerotic heart disease	?
Coronary occlusion	Sudden
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. T. Fidler M.D. M. D. or other

Address: Davidsonville, Md. Date signed: 8-20-40

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

08322

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 2 yrs. 2 mos. 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: St. Mary's

City or town: Chaptico

(If outside city or town limits, write RURAL and give nearest town)

Street No. ------

(If rural, give LOCATION)

2.(a) If veteran, name war ------

3. (a) FULL NAME

SAMUEL TALBOT

3. (b) Social Security Number

------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	black	widowed

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.): 1858 ?

8. AGE: Years	Months	Days	If less than one day
82 ?	Unknown		...hrs. ...min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: General

FATHER

12. Name: John Talbot

13. Birthplace: Maryland

MOTHER

14. Maiden name: Ellen (Unknown)

15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 22 1940 (month) (day) (year)

Cemetery or crematory: [illegible] Methodist

Location: Chaptico, Md

18. Funeral director: Rose E. Welch

Address: Chaptico Md

19. 8/20 40 (Date rec'd by registrar) E. T. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 18th 1940 at 10:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25th 1938 to Aug. 18 1940

and that I last saw him alive on Aug. 18th 1940

Immediate cause of death	DURATION
Arteriosclerosis	
Due to	
Senility	
Due to	
Other conditions ------	

(Include pregnancy within 3 months of death)

Major findings of operations: ------

Date of op.

Autopsy results: ------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------ Date of

Where did injury occur? ------ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ------

Means of injury Injured at work? ------

23. SIGNATURE: [illegible] M. D. or other

Address: Crownsville, Maryland Date signed: 8/19/40

RECEIVED
SEP 5 1940
BUREAU V. S.

08323

STATE OF MARYLAND—CERTIFICATE OF DEATH

(159)

1. PLACE OF DEATH

County A.A. Co. Registration Dist. No. 2-B

Village or City Benefield No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Premature infant Thompson If U.S. Veteran, specify WAR

(a) Residence: No. Benfield Millersville St., P.O. Ward

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE W.

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) X

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, and year) Aug. 6th 1940

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Millersville P.O. A.A. Co. Md.

FATHER

13. NAME Paul Thompson

14. BIRTHPLACE (city or town) (State or country) Maryland.

MOTHER

15. MAIDEN NAME Anne Leaf

16. BIRTHPLACE (city or town) (State or country) Millersville Maryland.

17. INFORMANT (Address) Paul Thompson Millersville, Md.

18. BURIAL, CREMATION, OR REMOVAL Place Millersville Cem. Date Aug 6, 1940

19. UNDERTAKER (Address) Paul Thompson Grandfather

20. FILED Aug 6, 1940 Mrs. DeAlba Dep. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Aug (Month) 6th (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

I last saw h alive on , 19 ; death is said to have occurred on the date stated above, at m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

Premature Infant

Date of onset

Other **Contributory Causes** of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury , 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) J. G. Alexander M. D.

(Address) Glen Burnie, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

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SEP 5 1940
BUREAU V. S.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

08324

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: St. Margarets

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A A.

City or town: St Margarets

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Harry Jones Tuck

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12th 1867

8. AGE:

Years	Months	Days	If less than one day
73	3	16	hrs. min.

9. Birthplace Annapolis Md.

(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Washington J. Tuck

13. Birthplace A A Co Md.

MOTHER 14. Maiden name Lucy Jones

15. Birthplace A A Co Md

16. Informant Mary Welsh

Address 29 Southgate Ave Annapolis Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof Aug 29th 1940 (month) (day) (year)

Cemetery or crematory St Annes

Location Annapolis Md

18. Funeral director John M. Taylor

Address Annapolis Md.

19. 8-29 1940 J. J. Murphy Jr. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 28 1940, at 8 17 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 24 1940, to Aug. 28 1940

and that I last saw h[illegible] alive on August 26 1940

Immediate cause of death	DURATION
Cerebral Hemorrhage	Aug. 24
Due to Arteriosclerosis	Unknown
Due to Hypertension	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C Bair M. D. or other

Address Annapolis Date signed 8-28-40

RECEIVED
SEP 5 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (R3)

08325

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County A.A.

City or town Riva
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: South River

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 3 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County A.A.

City or town Homewood Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 134 Woodland & Maple Ave
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR None

3. (a) FULL NAME Herbert E. Tucker

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23 1911

8. AGE:

Years	Months	Days	If less than one day
29	3	17	hrs. min.

9. Birthplace A.A. County
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Road Work for A.A.County

FATHER
12. Name Norman E. Tucker
13. Birthplace A.A. County

MOTHER
14. Maiden name Lucy B. Asquith
15. Birthplace A.A. County

16. Informant Norman E. Tucker
Address Homewood. Annapolis, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 13 1940 (month) (day) (year)

Cemetery or crematory Hope Chapel

Location South River

18. Funeral director B.L.Hopping
Address Annapolis, Md.

19. 8 12 1940 (Date rec'd by registrar) J J Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 10, 1940, at 6 30 p M

21. I CERTIFY that death occurred on the date above stated; [redacted]
Post mortem examination
[redacted] Aug. 10, 1940.

Immediate cause of death Drowning

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 8/10/40

Where did injury occur? Riva (City or town) A.A. (County) Md (State)

Injured at home, farm, industry, public place (where?) South River

Means of injury drowning Injured at work? no.

23. SIGNATURE John M. Claffy Deputy medical examiner M. D. or other

Address Annapolis, Md. Date signed 8/12/40

RECEIVED
SEP 5 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08326

(94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Bay Ridge
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 3 Mayo Ave.

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): — 2 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 2843 Lake Ave.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Agnes M. Vahle

3. (b) Social Security Number:

4. Sex: female

5. Color or race: white

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Charles Vahle

6(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): Sept. 22. 1871

8. AGE: Years 68 | Months 10 | Days 25 | If less than one day ___ hrs. ___ min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business: Home

FATHER
12. Name: Frank Bury
13. Birthplace: Germany

MOTHER
14. Maiden name: Miss Schaffer
15. Birthplace: Baltimore

16. Informant: Charles Vahle

Address: 2843 Lake Ave., Balto. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8, 19, 40 (month) (day) (year)

Cemetery or crematory: Parkwood

Location: Parkville, Md.

18. Funeral director: William J. Tickner + Sons.

Address: North + Pa. Aves.

19. 8 18 1940 (Date rec'd by registrar) J J Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 17 1940, at 1 45 A M

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post mortem examination, ~~and that I last saw~~ ~~alive on~~ 19

Immediate cause of death: Coronary occlusion — DURATION: sudden

Due to:

Due to: Arterio-sclerosis

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations: / / / / /

Of autopsy: / / / / /

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: / / / Date of: /

Where did injury occur? / (City or town) / (County) / (State)

Injured at home, farm, industry, public place (where?): /

Means of injury: Injured at work?

23. SIGNATURE: John M. Caffy Deputy medical examiner M. D. or other

Address: Annapolis, Md Date signed: 8/17/40

RECEIVED
AUG 23 1940
BUREAU V. S.

Dr. Claffey

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-c)

CERTIFICATE OF DEATH

Reg. Dist. No. 21 08327

1. PLACE OF DEATH:

County A. A.

City or town Annapolis
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County A. A.

City or town ~~Annapolis~~ Camp Parole Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. ~~Emergency Hospital~~
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Robert Wells Jr.

3. (b) Social Security Number None

4. Sex Male

5. Color or race Colored

6. (a) Single, married, widowed, or divorced single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 2 1933

8. AGE: Years 7 Months 9 Days 4 If less than one day hrs. min.

9. Birthplace Camp Parole, Md
(Town, county, and state)

10. Usual occupation School boy

11. Industry or business

FATHER
12. Name Robert Wells
13. Birthplace Annapolis

MOTHER
14. Maiden name Mary Dobson
15. Birthplace Annapolis

16. Informant Mary Wells
Address Camp Parole

17. Burial
(Burial, cremation, or removal, Which?)
Date thereof Aug 13/1940 (month) (day) (year)

Cemetery or crematory Brewer Hill

Location Annapolis

18. Funeral director J. B. Johnson
Address Annapolis

19. Aug 13 1940 (Date rec'd by registrar) J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 9 1940, at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post-mortem Examination ~~and that I last saw it alive on~~ Aug. 9. 1940

Immediate cause of death Ruptured Stomach (cardiac end) Torn Mesentery

~~Due to~~ Shock.

Other conditions

(Include pregnancy within 3 months of death)

Major findings: Ruptured Stomach (cardiac end) Torn mesentery

Of operations

Of autopsy none

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident ? Date of 8/9/40.

Where did injury occur? Parole (City or town) A.A. (County) Md (State)

Injured at home, farm, industry, public place (where?) Highway #50.

Means of injury automobile truck Injured at work? no

23. SIGNATURE John M. Claffey Deputy medical examiner M. D. or other

Address Annapolis Md Date signed 8/13/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08328

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 22 yrs. 7 mos., 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1004 E. North Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: ------

3. (a) FULL NAME: MARY WILLIAMS

3. (b) Social Security Number: ------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	black	married

6.(b) Name of husband or wife: Unknown
6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1883 (?)

8. AGE: Years	Months	Days	If less than one day
57(?)	Unknown		...hrs. ...min.

9. Birthplace: Pennsylvania (Town, county, and state)
10. Usual occupation: Seamstress
11. Industry or business: -----

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 8/22-40 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville Md
18. Funeral director: Supt.
Address:

19. 8/26-48 (Date rec'd by registrar) ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 17th 19 40, at 6:40P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 16th 19 18, to Aug. 17th 19 40
and that I last saw her alive on Aug. 17th 19 40

Immediate cause of death	DURATION
Broncho pneumonia	
Due to	
Due to	
Other conditions: Chronic myocarditis	

(Include pregnancy within 3 months of death)

Major findings of operations: -----
Date of op.:
Autopsy results: -----
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ----- Date of
Where did injury occur? ----- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) -----
Means of injury: Injured at work? -----

23. SIGNATURE: Albert V. Stinebrake M. D. or other
Address: Crownsville, Maryland Date signed 8/17/40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
SEP 5 1940
BUREAU V. S.

Dr. Bazil

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-B)

CERTIFICATE OF DEATH

08329

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County A. A.
City or town Annapolis
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or Inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Md. County A. A.
City or town Annapolis Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 10 Greenville
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME William Wilson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Mary Wilson
6(c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) June 10 1884

8. AGE: Years	Months	Days	If less than one day
56	1		hrs. min.

9. Birthplace South River (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business

FATHER 12. Name Charley Wilson
13. Birthplace A. A. Co.

MOTHER 14. Maiden name Sarah Wilson
15. Birthplace A. A. Co.

16. Informant Mary Wilson
Address 10 Greenville

17. Burial Date thereof Aug 13/40
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Brewer Hill
Location Annapolis
18. Funeral director J. B. Jones
Address Annapolis

19. Aug 13 1940 J. H. Murphy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 10 1940, at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 13 1940, to Aug. 10 1940, and that I last saw h in alive on Aug. 10 1940.

Immediate cause of death	DURATION
Carcinoma Stomach	unknown
Due to	
Due to	
Other conditions Arteriosclerosis	unknown
Secondary anaemia	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE George C Bard
M. D. or other
Address Annapolis Md. Date signed 8-12-40

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SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-6)

08330

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Anne Arundel

City or town Mayo

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 31 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A. A. Co.

City or town Mayo Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR None

3. (a) FULL NAME Ellwood Carll Witt

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Lillian Geneva Witt

6(c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) August 7 1909

8. AGE:

Years	Months	Days	If less than one day
31	0	6	hrs. min.

9. Birthplace Mayo, Md. A. A. Co. (Town, county, and state)

10. Usual occupation Fishing & oystering

11. Industry or business

FATHER

12. Name William Witt

13. Birthplace Germany

MOTHER

14. Maiden name Wilhelmina Behlke

15. Birthplace Shadyside, Md.

16. Informant Mrs. Edward Cummings

Address Edgewater, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 16, 1940 (month) (day) (year)

Cemetery or crematory Methodist Church

Location Mayo, Md.

18. Funeral director T. A. Hardesty & Son

Address Galesville, Md.

19. Aug 15 1940 Edw Collinson

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1940, at 5:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1938 1940, to Aug 12 1940, and that I last saw h alive on Aug 13th 1940.

	DURATION
Immediate cause of death Coronary Thrombosis	8 months
Due to Mitral Stenosis	uncertain
Due to Cardiac Enlargement	1938
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Geo. C. Bond M. D. or other

Address Annapolis Md Date signed 8-14-40

RECEIVED
SEP 7 1940
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 550

CERTIFICATE OF DEATH

08331

Reg. Dist. No. 1

1. PLACE OF DEATH:

County Anne Arundel

City or town West Annapolis

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or Institution:

Stay in hospital or Inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town West Annapolis Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Emily M. Dampas Zapp.

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife August D. Zapp.

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23d 1881

8. AGE:

Years	Months	Days	If less than one day
59		19	hrs. min.

9. Birthplace England

(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name John Collins

13. Birthplace England

MOTHER 14. Maiden name Unknown

15. Birthplace Unknown

16. Informant August Dampas.

Address West Annapolis A.A.Co Md.

17. Burial Date thereof Aug 14th 1940

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Naval Artillery

Location Annapolis Md.

18. Funeral director John M. Taylor

Address Annapolis Md.

19. Aug 13th 1940

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1940, at 9 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1940 to Aug. 12 1940, and that I last saw her alive on Aug. 12 1940.

Immediate cause of death	DURATION
Carcinoma of pelvis	1 year
Due to	
Due to	
Other conditions Secondary anaemia	1 year
Acute cystitis	3 mo.

(Include pregnancy within 3 months of death)

Major findings:

Of operations none

Of autopsy no

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Willis Martin M.D.

M. D. or other

Address Annapolis Md Date signed 8/12/40

RECEIVED
SEP 5 1940
BUREAU V. S.